Parliament Chiropractic, LLC

David W. Parliament, DC
2665 E. Tudor Rd, Suite 201
Anchorage, AK 99507
Phone: (907)222-5100 Fax: (907) 222-5412
www.ParliamentChiropractic.com

Date:_____

Patient Demographics

Name:_____ **Date of Birth**:_____ **Age**:_____
(last) *(first)* *(Initial)*

Home Phone:_____ Cell Phone:_____

E-mail:_____

Residential Address:_____

City:_____ State:_____ Zip:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Sex: Male Female Marital Status: Married Single Widowed Divorced
Social Security Number:_____

Occupation:_____ Employer:_____
Employer's Address:_____ Work Phone:_____
City:_____ State:_____ Zip:_____ May we call you at work? Yes No

Name of Spouse (or parent):_____ Occupation:_____
Emergency Contact and Relationship to you: _____ Phone:_____

Person Authorized to Discuss Your Account or Medical Record: _____

Referred to our Clinic by:_____
(Thank You for Your Referrals)

I, the undersigned agree that the above information is true and correct to the best of my knowledge:

Patient Signature *(or legal guardian if minor)*:_____ Date:_____

Confidential Patient Information (HIPAA)

HIPAA:
Due to the Health Insurance Portability and Accountability Act (HIPAA), we are required by Applicable federal and state law to maintain the privacy of your health information. We are also required to give you a Notice about our Privacy Practices, our legal duties and your rights concerning your health information.
Do you want a copy of our Notice of Privacy Practices? *(Please Circle)* Yes No
If "Yes" it is your responsibility to acquire a copy from Parliament Chiropractic, LLC

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Insurance Information and Financial Policy

Are you personally insured? Yes No

And/or are you insured under your spouse's or any other policy? Yes No

Are you insured by Medicare or Medicaid? Yes, which one: _____ No

Primary Insured's Name:_____ Date of Birth:_____

Insurance Company:_____ Policy No:_____

Secondary Insured's Name:_____ Date of Birth:_____

Insurance Company:_____ Policy No:_____

Guarantor Information:

Name:_____

(*Last*) *(First)* *(Initial)*

Relationship:_____ SS#:_____

Phone:_____ Work Phone:_____

In exchange for Parliament Chiropractic, LLC (Clinic) forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows:

I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjusters responsible or claims filed by me, administrative agencies, the Alaska Workers' Compensation Board and my attorneys. To the extent of my unpaid bill to the Clinic, I hereby irrevocably assign to said Clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative and direct my legal representative that at the time of final judgment, final disposition or settlement this assignment shall have priority over all others not entitled by law of superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company; employer or legal representative shall be paid ***directly*** to Parliament Chiropractic, LLC and will be credited to my account upon receipt. If payment is insufficient to pay for all my indebtedness, I will remain liable to Parliament Chiropractic, LLC for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, are charged directly to me and that **I am personally responsible for payment** and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such an event, I agree that this assignment will remain effective until all sums I owe the Clinic are fully paid.

Patients Signature:_____ Date:_____

Patients SS#:_____ Insured's SS#:_____ Drivers Lic No:_____

_____

(Legal Guardian's Signature authorizing care of a minor and Payment) *(Date)*

Parliament Chiropractic, LLC
Consent for Purposes of Treatment, Payment and Healthcare Operations

I,_____(Name of Individual) consent to Parliament Chiropractic, LLC ("the Practice's") the use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

PARLIAMENT CHIROPRACTIC

New Patient Pain Diagram

Patient's Name

Sensations Chart:

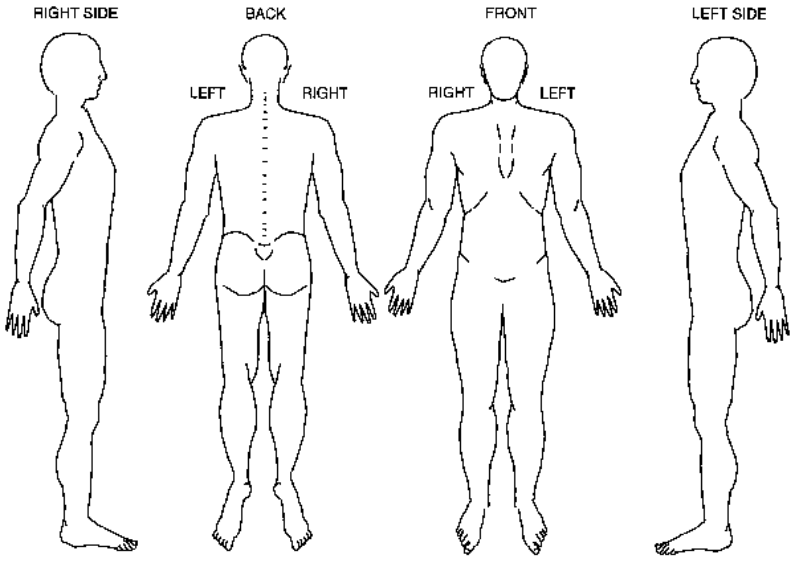
Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation.

Include all affected areas.

Numbness = = = Pins and needles 000 Burning xxxxx

Stabbing and Sharp Pain ///

Dull Deep Pain, Ache, Pressure or Pulling + + +



A) I have to get out of bed at night to walk around in order to obtain relief from back/leg pain. Y N

B) My back sometimes gets "stuck" when I bend forward. Y N

C) My back feels like it is going to give way when I bend forward. Y N

D) My pain stops me after I walk a certain distance. Y N

E) After walking, bending forward decreases my pain. Y N

F) Coughing or sneezing aggravates my condition. Y N

G) Bowel movements cause pain to my back. Y N

H) I am having difficulty and/or pain with urination. Y N

I) Swallowing is difficult for me and/or causes pain. Y N

PAIN SCALE AS INDICATED BY PATIENT

On a scale of zero to ten, I rate my discomfort/pain as follows:

)----------(

0 no pain 10 severe pain

Neck and Upper Back	☐	Arm(s)	☐	**I TYPICALLY HAVE:**	
Mid Back	☐	Leg(s)	☐	☐	High Pain Threshold
Lower Back	☐	Head (Headache)	☐	☐	Normal Pain Threshold
				☐	Low Pain Threshold

Comments:

Date Patient Signature

Health History

Please Print. ***Thank You***

Have you seen a Doctor of Chiropractic before?_____

Your Major Complaint(s) Today and the Purpose of your Appointment:

_____

_____

Other Doctors seen for this condition:_____

(Doctors Name) *(Type of Doctor)*

Diagnosis:_____ Treatment:_____

Length of care:_____ Results:_____

Have you ever been treated for any other health condition by a Medical Physician or Chiropractor in the last year?

Yes No Describe:_____

Date of Last Physical Examination:_____

TO ENABLE US TO PROVIDE AN EFFECTIVE HEALTH CARE SERVICE, WE REQUEST THAT YOU COMPLETE THE FOLLOWING HEALTH HISTORY.

Fractures or Breaks:_____

(Which Bone?) *(Date?)*

Surgery:_____

(Type) *(Date?)*

Major Accidents or Injuries *(what happened and When?)*:_____

_____

Current Drugs or Medications (Type?):_____

_____

Unusual or Contagious Disease or Condition:_____

(Name of Condition)

_____

(*Date Diagnosed)*

Do you presently have any health condition that we should be aware of, Such as *(Please Circle)*:

Pregnancy Yes No Diabetes Yes No Epilepsy Yes No Heart problems Yes No Contagious Disease Yes No

Other:_____

_____

Family: Hereditary and Constitutional factors play an important role in your health!

Have any of your Blood Relatives *(Parents/ Brothers/ Sisters)* Had any of the following Conditions *(please circle Yes or no)*

Yes No Diabetes Mellitus	Yes No High Blood Pressure	Yes No Arteriosclerosis	Yes No Gout
Yes No Heart Disease	Yes No Degenerative Disc Disease	Yes No Cancer	Yes No Arthritis
Yes No Abnormalities and Deformities of the Spine		Yes No Curvature or Scoliosis of the Spine	

Social and Marital: ***Please discuss personally with your Chiropractor any situation that is affecting your health and happiness.***

Patient Signature *(or legal guardian if Minor)*:_____ Date:_____

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Consent to X-Rays

Today's Date:_____

Name of patient:_____Birthday:_____

I give consent for X-Rays to be taken of me and / or my child. I will not hold Dr. Parliament's office responsible for any occurrences having to do with the X-Rays that are taken at this clinic.

Signature: Patient / Guarantor _____

Guarantor Print Name _____

WOMEN: I understand that if I am pregnant and have X-Rays taken which expose my lower torso to radiation it is possible to injure the fetus. I have been advised that the 10 days following the onset of menstrual period is generally considered being safe for X-Rays.

With the full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I acknowledge consent in the event an X-Ray examination is to be performed.

Signature: Patient / Guarantor_____

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Massage Therapy Policies

General Information

Therapeutic massage therapy is a treatment we offer here at Parliament Chiropractic. Massage therapy hours are Monday through Friday from 9:00am-6:00pm. To schedule an appointment, please contact the front desk at #907-222-5100.

Cancellation Policy

Massage appointments can be rescheduled or cancelled free of charge if we are notified at least 4 hours before your appointment. Cancelled or missed appointments will be subject to a $60 cancellation fee if the 4 hour notice was not given, no call/no show occurs and/or either happen more than twice in a 6 month period. Insurance will not be billed for this charge.

Financial Agreement

- I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
- I have read the policy above and understand them.
- I understand I am financially responsible for all charges, whether or not they are covered by my insurance.

Therapeutic Massage Guidelines

- Arrive 15 minutes early to your appointment.
- Arrive freshly showered and free of perfumes and odors.
- Undressing to your comfort level is acceptable. If you choose to remain clothed, your garments will get massage cream or lotion on them.
- Any inappropriate or unprofessional behavior will not be tolerated. Your session will be terminated at the therapist's discretion if you fail to abide by this policy.

I understand and agree to this Financial & Cancellation Policy.

Patient (or Guarantor) Signature:_____ Date:_____